UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF ALASKA

KIMBERLY ALLEN, Personal Representative of the ESTATE OF TODD ALLEN, Individually, on Behalf of the ESTATE OF TODD ALLEN, and on Behalf of the Minor Child PRESLEY GRACE ALLEN,

Plaintiffs,

vs.

UNITED STATES OF AMERICA,

Defendant.

Case No. A04-0131 (JKS)

COPY

VIDEOTAPED DEPOSITION OF MICHAEL LEVY, MD

Pages 1 - 195, inclusive

Friday, February 24, 2006
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Taken by Counsel for Plaintiffs
at
ASHBURN & MASON
1130 West 6th Avenue, Suite 100
Anchorage, Alaska

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more time -- I did all my emergency stuff, but I also spent more time with the internal medicine side of it as well as having my own clinic for -- I forget now. I think it was about three years while I was a resident there.

Q. And when you say your own clinic, what do -- what do you mean?

A. I had a clinic -- when you're an internal medicine resident, you have a clinic and patients you're responsible for a couple times a week during the two or three years of your residency, so you do your regular stuff, your hospital stuff, and then you would come in and see patients that have been assigned to you who would be returning to you on an ongoing basis, that you're treating blood pressure and diabetes and various such things.

Q. Are there subspecialties within emergency medicine, or were -- when you refer to subspecialties, was that within some -- some other group, some other --

A. Well, there actually are. There's -- there's gerontology, there's sports medicine, there's critical care or other fellowship boardings that you can get associated --

Q. Okay.

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A. -- with emergency medicine.

Q. In -- in regards to your board certification in emergency medicine, is it generally in emergency medicine, or is it --

A. Yeah. I'm board certified in both emergency madicine and internal medicine.

Q. All right. And I saw that you're -- you were recertified in emergency medicine in 1998. Is there -- is there a requirement that you be recertified every ten years?

A. With emergency medicine, there is.

Q. With emergency medicine. And how about with internal medicine?

A. There isn't for my year, so I just have to keep up with my CE's and the like. They do have a pathway for that, which I have been doing their CE's, but I haven't gone through the --

Q. Okay.

A. -- recertification because I don't have to.

Q. And then are you -- is your pra- -- current practice now emergency medicine?

A. Yes.

Q. Do you feel like you're practicing internal medicine? I -- I assume that there's some overlap between internal medicine and emergency medicine,

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but is -- is basically your practice comprised of -- of working in an emergency room?

A. 100 percent emergency medicine, but the training I received in internal medicine is kind of integral to that.

Q. Okay. What's -- what is the difference between the training that a family medicine physician undergoes versus emergency medicine physidan? And can you be board certified in family medicine?

A. Yes --

Q. Can you? Okay.

A. -- you can. I guess I can't be real expert in talking about family medicine, what their -- their focus, though it just generally has to do more with being the medical home for people, ongoing care from cradle to grave basically, so doing pediatrics and then adolescent and adult care; and mostly focusing on, you know, health promotion, disease prevention, I think.

So taking care of chronic illness, doing the usual immunizations, kind of the whole gamut of stuff, but not looking to -- and more intense focus, like emergency medicine would with regard to the acute emergencies we see; and then less like internal

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medicine, in that internists are trained to a more specific level for adult disease and more complex adult disease, which a family practitioner would probably refer many cases to an internist or an internal medicine subspecialist.

Q. Okay. Since -- since completing your residency -- and that was four years?

A. Yes.

Q. And is that in part because you were doing the internal -- I'm sorry -- a residency in internal medicine and emergency medicine together?

A. Yes.

Q. All right. And then you were chief resident, emergenc- -- emergency medicine at McGaw Medical Center. Is -- where is that? Where is McGaw?

A. That's Northwestern University in Chicago and the Gold Coast.

Q. Okay. And that's -- and as chief resident, what generally were your responsibilities?

A. I was a fourth-year resident at the time, and so, in addition, I had a leadership role with regard to the residency, and interface with the attending staff, teaching responsibilities, and scheduling.

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Q. Okay. If you could describe for me right, currently, what is your -- what's your current practice?

A. I'm an emergency physician. I'm the chairman of the emergency medicine department at Regional. So my -- I spend a hundred percent of my time doing clinical work, seeing patients with all manner of emergency.

Q. Okay. Are you involved in training medical students through the WWAMI program or any sort -- other sort of program?

A. We occasionally have medical students, but they're not through WWAMI. They come from places like Scotland and the like, through just associations that some of our partners have had with them.

Q. Okay. So -- so have you been involved in at least training some -- some medical students who are --

A. I have trained medical students, yes.

Q. All right. How about working with people in emergency medicine -- let me go back to the first page of your CV. It says National Association of EMS -- oh, that's emergency medicine physicians. Is that correct?

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A. EMS, emergency medical services physicians.

Q. Okay. Do you work with training paramedics?

A. Yes.

Q. Okay. And -- and I guess EMTs, emergency medicine technicians. Is that what that stands for?

A. They're all -- yeah. A paramedic is technically an emergency medical technician, hyphen P, so the highest level of EMT is paramedic.

Q. Okay. And you're involved in training --

A. Yes.

Q. -- in paramedics and -- and the like?

A. I was head of the -- I was the medical director for the Paramedic Academy here in town for four or five years, and since then I am not doing that right now. And when it's become MTI with a security and that thing over there, I -- I left them then, but up till that point I was with -- Aurora North is what the academy was before, and it became NorthStar Academy.

Q. Okay.

A. And after NorthStar it became MTI. And at that time I left, but --

Q. Okay. But are you familiar with the sort of medical training the paramedics --

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A. Oh, sure.

Q. -- have?

A. Well, in addition, I'm the medical director for the Anchorage Fire Department. So I'm in charge of areawide EMS, is really my most recent title. And I'm the past chairman of the medical advisory board on EMS for the mayor.

Q. Okay. And what year was -- what year were you in that position?

A. I've been in it since 1995.

Q. Okay. So you're currently in -- so you're currently in that position?

A. Yes.

Q. Okay. And you've been doing it for the last 11 years?

A. Uh-huh.

Q. Okay. It looks like you worked at Alaska Native Medical Center from July '89 to June '90. Is that correct?

A. Correct.

Q. And then why did you end up leaving there?

A. I had a commitment to the National Health Service Corps that began after my -- after I finished my residency. It was a three-year commitment.

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Q. Okay.

A. And so it expired. And I was done with it. At that point in time, I didn't really wish to continue in the National Health Service Corps.

Q. Okay. And it's called the National Health Service Corps?

A. Yes.

Q. And what's the -- I'm sorry. What was the commitment? I'm not sure I understand that.

A. Well, I expend- -- I attended a very expensive medical school.

Q. Okay. And so you committed to work --

A. Year for year for tuition.

Q. Okay. And -- and what's the -- and you said it's a -- it's a three-year program?

A. For me, I signed on for three years. I -- because it's just the way the fourth year in my medical school was structured, it wasn't as expensive for me as the first three years. And, you know, I frankly didn't want to have any more time with the National Health Service necessarily than I had to. I didn't want to commit to that. I wanted to volunteer. I thought it was different. But anyway, so I was able to do that for three years, and that was my commitment time. So I had spent two

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with a colleague who is a -- he's a physician, JD.
Q. A physician, JD, somebody not in Alaska?
A. Not in Alaska.
Q. Okay. And what --
A. Without mentioning names or places --
Q. Sure.
A. -- or people or times.
Q. And what was your -- what was the -- the purpose of that conversation?
A. The purpose was really more or less to fill time. This is a friend who thrives on talking about such things, quite honestly, and he's got his perspectives on things. And so I think it was more just that kind of conversation.
Q. This friend of yours, does he practice -- I'm just curious if he's practicing law or practicing medicine.
A. Medicine.
Q. Okay. Is he one of the -- is he somebody who went to -- who was a lawyer and then became a doctor, or was he a doctor and then became a lawyer?
A. Doctor, became a lawyer.
Q. Okay. I don't ever see it the other way around. All right. Do you actually -- do you work for a group that works at Alaska Regional, or are

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you an actual employee of Alaska Regional?
A. We have a corporation, and we're a contractor to Alaska Regional.
Q. Okay. And is there -- how many people are in your group?
A. There are seven of us.
Q. And then are -- is there any particular hierarchy within the group?
A. There's -- it's a partnership with a partnership track, and we currently have just matriculated our -- the most recent person as a partner. And we actually have one hired person right now, so that would be the only hierarchy per se. Then we have one person we call our president.
Q. Okay. And are -- do you have a position in this --
A. I'm a vice president.
Q. Vice president, okay. Now, on the second page of your CV, under "Other Professional Positions," it says, "Medical director, AeroMed International." And what is that?
A. AeroMed International is a med-evac service owned by YK Delta Corp.
Q. Okay. And what's your -- you're the -- are you currently the medical director?

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A. I'm not.
Q. Okay.
A. I have worked with them since 2001, and I'm not currently the medical director.
Q. All right. But is it a group that you work with?
A. It's a group I had worked with until about five months ago, on projects prior.
Q. And is that what you were referring to before, that you had -- no longer have an association with this group --
A. No.
Q. -- or was that something else?
A. There's also -- MTI is the one I said.
Q. MTI. I'm sorry.
A. Yeah.
Q. What is MTI?
A. Medical Training Institute. It's the one you see in the paper these days associated with all the hubbub.
Q. With the Security Aviation?
A. (Witness nods head.)
Q. Got you. Okay. What was your -- I just wanted to get an understanding of what exactly you did. You were a medical director for AeroMed

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International --
A. Uh-huh.
Q. -- and then what did that -- what -- the medical director, what did that entail?
A. Right. Well, I established protocols and standing orders for the service, and reviewed 100 percent of the med-evacs, provided on-line medic control, and shared some of those duties with some of my partners at Denali Emergency Medicine Associates, which is my group. And I flew in the aircraft a few times. And then we would have monthly staff meetings, where I provide training and feedback.
Q. And the "staff" meaning to the -- were they physicians, or was this -- would be -- this be the paramedics, or who were the staff?
A. The crews were paramedics and flight RNs.
Q. Okay.
A. So that would be the component of those.
Q. And what -- what sort of aircraft are we talking about that were used for med-evacs?
A. The typical aircraft used when I was with them were Lear 35, Lear 36 -- there's a Lear 25 which was used sometimes. They were Citation jets. In the village, they had one Caravan with Grant

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Aviation, and then there was occasional use of, I think, a Conquest.
Q. Ever use helicopters?
A. No. Well, they could be involved in the village, in a helicopter rescue, insofar as the Army National Guard in Bethel has a Black Hawk that's stationed out there. And so that was used for some village rescues.
Q. Okay. And generally what would AeroMed International -- in this med-evac group, where would -- I mean, generally where was it operating? Bringing patients into Anchorage or taking patients outside of Anchorage?
A. Typically it's bringing patients into Anchorage, although it also flew, not uncommonly, to Seattle, in particular.
Q. Okay.
A. It's based here. There were two bases of operation. There was a base in Anchorage at Signature East, and then there was a base at Grant Aviation out at Bethel.
Q. Got it. And was it -- is it un- -- was it uncommon or is it uncommon to med-evac patients out of Anchorage to Seattle?
A. No, it's not uncommon.

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Q. And would generally patients go to the University of Washington?
A. Most often, I think, although there were other destinations.
Q. Okay. Would Harborview -- is Harborview part of the University of Washington?
A. Yes.
Q. Okay. And are you familiar with Harborview? Have you been down there?
A. I -- you know, I have been down there. I have spent no time there.
Q. All right.
A. So I'm not familiar with it, I guess is the easiest way to say it.
Q. Have you ever accompanied a patient from Anchorage on a med-evac to Harborview?
A. No.
Q. Have you ever accompanied a patient from -- who was being med-evac'd from Anchorage down to Seattle, at all?
A. No.
Q. All right. So you must be familiar with then how the med-evac planes -- it sounds like they're really airplanes -- are -- are equipped.
A. Yes.

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Q. Would that be fair to say? Okay. And are they equipped to transport critically ill patients?
A. Yes.
Q. And are they equipped to allow the administration of medication intravenously to patients?
A. Yes.
Q. And could you administer anti-convulsants to patients who are being med-evac'd?
A. Yes.
Q. How about monitoring and controlling blood pressure of a patient in a med-evac?
A. Yes.
Q. So they're equipped to do that. Is that --
A. Yes.
Q. Are they equipped to monitor and control fluids in a patient?
A. Yes.
Q. All right. In your experience with med-evacking patients from Anchorage down to Seattle, whatever that destination within Seattle would be, are the patients generally accompanied by a medical professional, whether or not it's a paramedic or a physician or a nurse?
A. What type of patient are you talking about?

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Q. You tell me. Does it depend on the patient, depend -- is that the issue? Does it depend on how the patient is and what's going on with the patient? Does that determine who goes down with them?
A. Yes, because you could have a stable transport of a patient who is going for rehab that could be wheelchair-bound and could have just an escort in a commercial aircraft. You can have somebody who couldn't go commercial aircraft but still was not a sick patient per se, but just because of logistics, having to be in a stretcher, the like -- and they might go just with some sort of medical escort.
But for the missions that we flew, by and large, they would be people who were acutely ill and needed a higher level of care, et cetera, and they would be typically flown with a crew complement of a para- -- a flight paramedic and a flight RN.
Q. Okay. A flight paramedic and a flight RN. And how -- in your experience, how common is it that patients are med-evac'd; that is, in this last scenario that you were describing with a flight paramedic or flight RN, a critically ill patient, how often does that come about where a patient's

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med-evac'd from Anchorage down to Seattle?
MR. GUARINO: I guess it --
MS. McCREADY: Let's talk about --
MR. GUARINO: -- what time per- -- what time are we talking now?
BY MS. McCREADY:
Q. Sure. Let's talk about in just the last five years.
A. Well, you know, honestly, it would be easier to actually get the data as opposed to guess.
Q. Well, I don't know if you have a sense of it, and I certainly don't expect you to remember exact numbers but --
A. Sure. Let's say in a given month, it completely -- roughly. And it could change depending on diversion status. Hospitals, there's a lot of variables, but I certainly don't think it was unusual to fly ten missions, out of a total of 1200 a year to Seattle, let's say, a month.
Q. Okay. And I understand it could fluctuate down or up from that. And I want to get your experience dealing with -- I mean, obviously we're talking about a case that involves a -- a patient with a subarachnoid who ultimately was diagnosed with a subarachnoid hemorrhage and a suspected

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ruptured aneurysm. And I just wanted to ask about your experience dealing with patients with a subarachnoid hemorrhage.
Let's first confine it to when you were in medical school and -- and your residency. Did you have any experience dealing with patients with subarachnoid hemorrhages at least --
A. Yes.
Q. -- at that point? Okay. If you could describe that to me, what you remember.
A. A long time ago.
Q. Well, if you don't remember, that's fine.
A. We had -- at Northwestern, we had a neuro intensive care unit, we had a brand-new sparkling, beautiful sort of facility down there. And we had a lot of neuro intensive care patients. And so I'm sure I saw and took care of subarachnoid hemorrhage during that time, but I can't put a face or a time on any of the ones I took care of at that time.
Q. Okay. You can't remember any of the specifics? Nothing stands out, at least at this point?
A. Right.
Q. Is that fair? Okay. And how about since then? If you could -- and maybe we should work from

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the current time backwards.
A. Okay.
Q. So in the last five years, have you dealt with any patients that, at least -- at least to your knowledge, ended up with a diagnosis of a subarachnoid hemorrhage?
A. And I thought maybe that would be asked, and I was trying to reflect back on how many I might have seen. I believe I have seen three this year so far.
Q. Three this year, just in 2006?
A. Yes.
Q. Okay.
A. One of them -- and again, this could be -- it's at least that, because I can specifically remember these, and I think I got the right year, in terms of not -- not -- I'm sorry. Not 2006. That's wrong. 2005 is what I'm referring to.
Q. Okay.
A. I think 2006 would be zero so far.
Q. All right.
A. So it's 2005. I think I saw three, which -- one, which was completely obtunded, but turned out to have a subarachnoid hemorrhage; and two others that had a subarachnoid hemorrhage from

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an aneurysmal bleed.
Q. I'm sorry. Say --
A. From aneurysmal bleeding.
Q. Okay. And with the one patient presented obtunded that -- were -- were they comatose or --
A. Yes.
Q. All right. And then the other two, how did they present? And were these patients that you -- you actually had contact with, or were they just patients that you knew about?
A. These were my patients.
Q. Okay.
A. Yes.
Q. All right.
A. They were both very uncomfortable. Something was clearly wrong with them.
Q. Okay. And when you say they were -- I mean, what sorts of -- I mean, how did you know they ended up with a subarachnoid hemorrhage?
A. Because I scanned them --
Q. Okay.
A. -- and I followed the results and took care of them.
Q. Sure. And -- and I just want to ask you, since it sounds like you have a memory of those

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Q. Okay. And is that something that's written about in the literature, that is, subarachnoid hemorrhages being sort of misdiagnosed?
A. We've all -- it's -- it's a point of great concern for all emergency physicians that we might miss that.
Q. Okay. And why is that a point of great concern?
A. Because it's an easy diagnosis to miss.
Q. Okay. And why do you say that?
A. Headaches are very common.
Q. Okay. So headaches are very common and -- well, subarachnoid hemorrhage, is -- is that something that could be potentially fatal?
A. Sure. Yes, it is.
Q. And be fair to say that a small number of people who present with headaches actually have a subar- -- subarachnoid hemorrhage. Is that right?
A. Yes.
Q. Okay. But is it -- is there a statistically significant number of patients who present with headache that actually do have a subarachnoid hemorrhage?
A. Yes.
MR. GUARINO: I guess I'm not sure what you

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mean by "statistically significant." That -- that has no -- has no legal meaning. It's not defined. I mean --
MS. McCREADY: Well, did you under- --
MR. GUARINO: -- does that mean one percent is enough? Is -- is a half of one percent enough? Is --
MS. McCREADY: Well, that's not my question.
Q. Did you understand my question?
A. I guess I didn't. I thought -- well, you asked me whether some people have that, and I don't think that's what you were asking me about.
Q. Okay. Well, is it -- is it -- are there enough people who present with headaches who have a subarachnoid hemorrhage -- is that -- is that number great enough that it's of concern to emergency room physicians?
A. Any potential disease process that we would have the opportunity to diagnose and the opportunity to miss is a concern to us.
Q. Okay. But specifically with subarachnoid hemorrhages, I mean, is that something that's been a concern within the emergency medical profession for -- is it fair to say a few decades: They might miss that diagnosis?

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A. Yes.
Q. All right. And is that -- is that something that you have seen written about in the literature?
A. Yes.
Q. Is that something that you actually train -- when you're actually training your emergency room physicians or -- or personnel, is that -- is that something that you have actually discussed with them, that is, the diagnosis of subarachnoid hemorrhage?
A. Yes.
Q. Okay. And what do you generally -- in -- in your training of other physicians or care providers who are working in the emergency room, what -- what, in fact, do you train them -- or how do you train them in terms of making the diagnosis or suspect the diagnosis of a subarachnoid hemorrhage?
A. Well, the first thing is to always be vigilant, that it could be something different. It could be a subarachnoid hemorrhage, if they have a headache.
Q. Okay.
A. So we want to look for a change in the

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quality or nature of pain, pain that's more severe than what may have been experienced by the person in the past, the classic worst headache of one's life.
Q. And to do that, would you need to take a care- -- careful history of the patient?
A. Yes.
Q. And do you consider that to be the standard of care, that is, that you would take a careful history of a patient who presented with a headache?
A. The -- well, with any patient, we want to have sufficient information from them so we can make a diagnosis.
Q. Okay. So for any patient, would you agree that the standard of care is to take a care- -- careful history so that you can make a diagnosis of the patient?
A. Yes. We always wants to be careful. I mean, that's -- and I guess it just depends. One -- start splitting hairs in terms of how much one has to dress something up to call it a careful history, perhaps --
Q. Sure.
A. -- because in any given situation, a careful history could be a couple words.
Q. Okay. But -- but a -- fair enough. But at

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least with a patient presenting with a headache, you would want to understand the -- the quality of the pain?
A. Yes.
Q. And the -- the quality and nature of the pain, I think you said. Is that correct?
A. Yes.
Q. And whether or not the pain was more severe than pain they've had before?
A. Yes.
Q. All right. And whether or not, as you said, it could be the worst headache of their life. Is that right?
A. Yes.
Q. And how about the -- would the location of the pain make any difference?
A. The location of the pain I don't believe makes a difference per se.
Q. Okay.
A. Although if it has changed from their typical pain, I'll say, then that would be something a person might want to note.
Q. Okay. And how about the onset of pain? Would that be important?
A. Yes.

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Q. All right. And why would that be important?
A. The -- a more abrupt onset of pain may mean something a little different than pain that starts more gradually.
Q. Okay.
A. There are exertional headaches, for example, thunderclap headaches associated with sexual activity, those kind of things.
Q. Would you want to know what the patient was doing when the pain began, in addition to the -- whether or not it was abrupt?
A. If the patient stated that they had an abrupt onset of headache, then you might ask what they were doing when it started.
Q. Okay. But would that be something if -- if a patient -- in your practice, if the patient presents with a headache, do you ask them what the onset was and whether or not it was abrupt?
A. Yes.
Q. Okay.
A. What I might say more typically was: Is this one of your typical headaches? Was there anything unusual about the headache?
Q. Sure.

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A. So I might not say, was it abrupt, was it sudden in onset. It'd be sufficient for me if they said, "This is what I've had before."
Q. Okay. And -- and let me ask you if you -- you've dealt with patients who have chronic pain, I assume --
A. Oh, yes.
Q. -- working in the emergency room?
A. Yes.
Q. Okay. And would the -- is the standard of care different for a patient who has got chronic pain, in terms of taking a history, whether or not that's important?
A. The -- is the standard of care different? The approach to the patient is similar, but it's usually more focused, because typically the patient has had many prior experiences with the emergency department, with the health care system. And so quite honestly one can pretty much move forward and ask if anything has changed or if we're just dealing with the same thing. If they have other concerns, what -- what their main concern for being in the emergency department is on that day.
Q. Sure. If you've got a patient that presents at the emergency room with chronic pain, is

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one of the first things that you want to know whether or not they're there to get pain medication?
A. Well, that's always in there somewhere, isn't it? But the issue really is: What is it today that makes you want to come to the emergency department? If the issue is pain medication, sure, be upfront and say it. If it's something else, let me know, so I can figure out what it is.
Q. Okay. But you would want to know, with a chronic pain patient, whether or not -- if they're presenting with pain, whether or not that pain is different than what they've before?
A. Yes.
Q. All right. Well, let me ask this: If someone said, you know what, it's really not that important to take a history of the patient who presents in the emergency department with chronic pain, would you agree with that?
A. No.
Q. Would you agree that one of the primary functions of the emergency department in a hospital is to determine if a patient has a condition that's serious, treatable and urgent?
A. Yes.
Q. Okay. And would you agree that one of the

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here in Anchorage?
A. Yes.
Q. Okay. If a patient presents to an emergency room in a major medical facility complaining of pain of ten out of ten and -- and the information is given that he's taken pain -- pain medication --
A. Yes.
Q. -- and he still has pain, would that be significant to you as a provider?
A. I guess it depends what you mean by "significant."
Q. Well, would it be clinically significant in terms of how you might actually either question that patient or -- or deal with that patient?
A. I'm sure it would be significant, but it would not -- the prevalence of that complaint in this community and the magnitude of the complaint would put them in -- it was -- it was a very common, common thing.
Q. And when you say "this community," what do you mean?
A. It seems, just from my own observation, that Anchorage has a high prevalence of chronic pain, more so -- and in talking to physicians that

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we have as locums up here, they're all kind of shocked by how much chronic pain we -- and how many people are on chronic narcotics up here.
Q. Okay. And given that a patient such as Mr. Allen, who is a chronic pain patient, who would be presenting at the emergency room -- and actually let me back up for a second.
So that wouldn't -- let me just be clear. So if -- if the -- if you know -- if, as Nurse Ambrose testified, that she got information that he was reporting ten out of ten pain and that he had been taking his drugs -- taking all his drugs but still had pain, that wouldn't -- you don't think that that would necessarily go into the triage decision?
A. That he had taken all of his drugs?
Q. Yeah, and that he still had pain.
A. Oh, absolutely not.
Q. That wouldn't go into the triage decision?
A. No.
Q. All right. And so what would go -- well, first of all, did you get the triage policies from ANMC?
A. I did.
Q. Did you get them prior to writing your report, or do you know if you got them afterwards?

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A. Again, that's sort of that same thing. I was -- I'm -- I'm sure -- pretty sure I did, because I think I had basically the entire packet before I wrote my report.
Q. Okay. Well, did you get records after you wrote your report?
A. I don't remember when your expert's bibliography came through. There might have -- beyond that, I don't think there was any other records after my report.
Q. Okay. Is this triage policy at ANMC, is that -- is that something that's sort of familiar to you? I mean, is that similar to the triage policy that's at Alaska Regional emergency department?
A. Now we're transitioning to a new model, which is similar to this, which I'm not a hundred percent involved in right now. It hasn't been implemented.
Q. Okay. How -- what do you mean? How different -- I'm sorry. Is the --
A. It's -- it's very similar to this, but I can't go through it point by point and tell you whether or not they're the same or not.
Q. Sure.
A. The five-level thing seems to be the

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current approach nationwide, something like it or a variation on it.
Q. And what -- has -- has the approach been at Alaska Regional a three-level or a five-level or --
A. Regional is small enough that, honestly, we don't get too hung up on these levels. We are able to move people through in a timely fashion, so they're either brought back -- we try to do no triage out at the window. We try to bring everybody back to a room as soon as possible and higher-acuity people are taken back immediately.
Q. Sure. And let me ask you about that. At Alaska Regional -- and I understood that you work with a -- a group of other emergency room physicians. Is that right?
A. Yes.
Q. And then is there -- are there other also mid-level practitioners that work in the emergency department at Alaska Regional?
A. No.
Q. Okay. Is it staffed only by emergency room physicians?
A. Yes.
Q. And so you don't work with physician's assistants. Is that correct?

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Q. Okay. And what's that based on?
A. The fact that the triage nurse didn't think he looked like he was in severe pain.
Q. Okay. And do you know what the triage nurse -- you read her deposition. Do you know what she based that on?
A. I read it. And I haven't read it in a while, but she just based it on her past experience, was my recollection.
Q. Her past experience with Mr. Allen. Is that right?
A. No, I don't know whether it was him per se.
Q. Oh, okay.
A. We should review that, if that's the point. But I don't.
Q. Sure.
A. It was just she's been doing that a long time and she's seen a lot of patients, was my understanding on it.
Q. And I'm just curious. With your experience with triage nurses -- because I assume that you work with them. Is that correct?
A. Yes.
Q. And do you ever -- do you actually supervise the triage nurses at Alaska Regional?

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A. I'm not in their direct chain of command there. They have their own hospital command.
Q. Got it. But you certainly work with them and --
A. And I would feedback to them if I had concerns about triage.
Q. Okay. And do you -- I'm just curious: In your experience, would it concern you if a triage nurse -- if a patient came in and reported a certain level of pain, and the triage nurse just decided on her own that that patient didn't have that level of pain?
A. No, it wouldn't concern me at all.
Q. Okay.
A. In a given setting, it did. So I can't make a broad sweep there.
Q. Sure.
A. If a gentleman was sitting out there, a lady was sitting out there with a fracture, dislocation of the ankle, that was untreated and the person was in extreme pain, then I would be very concerned about that, and we would have to reassess how that was arrived at.
But when we get into the extremely subjective notion of the pain scale, which has, for whatever

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reason, been given an objectivity assigned to it, only because it's a number, a self-assigned number, then I have much less problem with that, of allowing somebody to make a subjective decision to allow the emergency department to run more smoothly.
Q. Do -- have you come to an opinion in this case as to whether or not Mr. Allen was in severe pain the morning of April 19, 2003, when he presented at the ANMC emergency room?
A. I have no doubt he was in pain.
Q. Okay. Do -- do you have an opinion about whether or not he was in severe pain?
A. That's very subjective. He was in pain. I mean -- and he suffered with pain a long time, and he seemed like a stoic individual. He had ten out of ten pain many times in his life which he didn't come to the emergency department, as far as I could tell from his past records.
Q. Right.
A. So did he have severe pain? He had pain of a level he had experienced before. And so was that the most severe pain or not? I'm not sure where you're going with that, but I think he had pain that was significant to him, though I'm not sure that was the main reason he came to the emergency department.

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Q. What do you think the main reason was that he came to the emergency department?
A. I think he came there because his ear hurt, and he wanted to know why he had ear pain and whether he had an infection.
Q. Knowing what we know about Mr. Allen and what happened to him later that day, that is, that he was rushed to Providence in essentially a comatose state, do -- do you -- does that make sense? I mean, do you agree with that, that he was rushed to Providence Hospital later that day essentially in a comatose state?
A. It's a fact.
Q. Okay. And then a fact that he suffered a subarachnoid bleed. Do you agree with that?
A. Yes.
Q. Okay. Knowing what we know about him, do you have an opinion about whether or not -- let me break this down into two piece- -- two places.
Within a reasonable degree of medical certainty, do you have an opinion about whether or not Mr. Allen had a subara- -- subarachnoid bleed the morning of April 19th, 2003, when he presented at ANMC?
A. No, I don't think you can believe -- you --

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what treatment he would get once he got down there or how specialized it was. I'm talking about the physical action of -- of med-evac- -- he's -- he's probably the best expert in the state on med-evacking of patients.

So that's my question, is whether a patient -- assuming Mr. Allen was in the state where he was actively bleeding and was in the neurological state that he appeared to be that afternoon, would he be med-evac'd out to another state for medical treatment at that point?

THE WITNESS: And again, that would be my opinion from that standpoint, that if he were an extremist, as he seemed to be here, we would not transport him to another state.

BY MR. GUARINO:

Q. And the time line as you presented it, in terms of his initial presentation in the morning and the -- the sort of estimates of time it would take to work him up for the day, would he have arrived -- had -- had a decision been made to med-evac him, would he have arrived in Washington, the state of Washington, whether it was Seattle or Harborview, whatever facility he might have gone to, would he have arrived in time -- before he began to bleed

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from that subarachnoid hemorrhage?

A. The estimation I can make from this: He would not have.

MR. GUARINO: Okay. It's too late to go through any other parts of your report, but I just want to make a note for the record that I'm not going to go through his report today. You've had the opportunity to look at it and question him about it.

But I will state again: To the extent there are opinions expressed in there to which Dr. Levy is qualified by training or experience to render opinions on in terms of medical care or in terms of practical experience, in terms of time line or med-evac procedures, you can expect that we'll -- we can offer him -- we will offer him or we -- we may offer him to testify on those. Nothing further.

FURTHER EXAMINATION

BY MS. McCREADY:

Q. Okay. Let me just follow up very briefly. On the pain assessment, on the patient initial assessment, which is Exhibit 8, what -- that page that Mr. Guarino was asking you about.

A. Yes.

Q. And it says, pain as it is now, pain at its worst, pain at its best.

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First of all, did -- did you ever receive Mr. Allen's work records? Do you have an understanding about whether or not he was employed?

A. I knew that he -- or I think I knew that he worked in a capacity for oil spill cleanup in Valdez, and he was off his meds for a period of time, on his meds for a period of time.

Q. Okay. And do you have any idea, before you filled this document out, whether or not he had been working in Valdez and not taking his pain medications?

A. I assume he was.

Q. You assumed he was --

A. Right.

Q. -- working? Is that what you -- is that what you meant? Okay.

A. I thought he was.

Q. And then with this -- where it says, "Frequency of pain flares during the last month," and it says "estimated 16," had you seen any visits that Mr. Allen had made in the past month to the ER complaining of pain?

A. In the month of January?

Q. Uh-huh.

A. I don't believe -- well, he was there on

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the 23rd, wasn't he, with -- and he's complaining of pain at that time. It wasn't the ER. It was the clinic.

Q. It was the clinic that he went to?

A. Yes.

Q. Was he at the emergency room complaining of pain --

A. No.

Q. -- in that past month?

A. No.

Q. Okay. When it says, "Pain at its worst," a ten out of ten, do we know whether or not his pain on April 19, 2003 was the worst pain he had ever had?

A. No.

Q. Well, do you know whether or not it was worse than when he -- it was worse than the pain he described when he filled this document out?

A. I don't know. I -- I routinely have people tell me they have 12 out of 10 pain and 13 out of 10 pain. So I don't know if he would exaggerate that way -- you know, if your -- if he needed more volume on the thing, but as far as I can tell, from the information I have, I have no way to say.

Q. Okay. You -- you can't say whether or not,

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when he -- when he presented at April 19, 2003, that was the worst pain he had ever had, and in fact, worse than what he described in his pain initial assessment form?

A. No.

Q. All right. When Mr. Guarino was asking you about would Mr. Allen have been a candidate to be med-evac'd down to Seattle if, in fact, he had had the -- as -- as he presented that afternoon at Providence, that is, with significant blood in his brain, and you said no, he wouldn't have been transported, would that be your call or would that be the call of a neurosurgeon?

A. Well, ultimately I would engage someone to share that with me.

Q. Okay. And who --

A. Now, I don't know it would be a neurosurgeon -- in this situation, quite honestly, it would probably be Dr. Kohler, if he was in town back then. I think he was.

Q. And is Dr. Kohler the neurosurgeon at ANMC?

A. Right, who did not perform this kind of surgery. But I believe -- and I -- I have to -- I would have to confirm this, but I believe he was in town.

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As a consequence, ANMC would want to have the final say, particularly if someone wanted to transfer their patient, Mr. Allen, to Seattle. And in the past, they have been very conservative.

I can tell you, for example, with burns, if we have burns that are over a certain percentage body area, that even if the person's alive and talking to you but has very low probability of survival, it's preferred that they stay here in Anchorage and die here.

Q. Does that end up then being your call or -- again, your call in terms of your decision about whether or not the patient is transported, or does it end up being -- does -- would ANMC, in that situation, then rely on the emergency room physician to make that decision about whether or not it makes sense to transport that person to Seattle?

A. In this specific case, I mean I would play out the scenario, too, that I would eval- -- if the person were in my care, then I would evaluate him. If I had the same findings, for example, over at Providence, then I would probably contact the neurosurgeon at ANMC, if there were such a person, and talk with them, get their opinion.

Q. And was Dr. Kohler the neurosurgeon -- was

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he at ANMC at the time that Todd Allen presented to ANMC?

A. That's that I'm saying. I don't really know.

Q. Okay.

A. I would have -- you know, go back and look at records and things, see when he came to town.

Q. Okay. If Mr. Allen had been stable, that is, neuro- -- neurologically intact and stable, would there be any question that he would be transported to Seattle?

A. The only question would be whether or not the local neurosurgeons would get involved in his care.

Q. Okay. And can you say whether or not the local neurosurgeons would get involved in his care?

A. There was a period of time when they wouldn't. And I don't know if this particular time, when he presented, was that time. There was a period of time when they were doing basically no aneurysm surgery up here.

Q. Okay. And do you have any -- do you know when they started doing that?

A. No. I was -- actually tried to find that out, and I wasn't very successful yet.

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Q. How --

A. And I still --

Q. How did you try to find that out?

A. I tried to see if I could get the neurosurgeons to look at their billing records for me to see if they were billing any aneurysm surgeries.

Q. And let me guess that you couldn't get them to do that.

A. (No response.)

Q. Okay. Were you -- did you talk to any of the neurosurgeons in town about this case?

A. Not this case per se. I talked to them in generalities without any reference to anything, just about, you know, would you operate on such a person as this or that?

Q. And what did you learn?

A. That unless -- that no one does emergency surgery in this town for aneurysms.

Q. That no one does emergency surgery in this town for aneurysms. That's what you learned?

A. For subarachnoid -- for -- for cerebral aneurysms.

Q. Sure. And was that the case in 2003?

A. And in terms of -- by "emergency surgery,"

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I mean, you know, 5:00 o'clock in the afternoon with a diagnosed subarachnoid hemorrhage in a person who is -- pick your Hunt & Hess. They are not going to go to the operating room in this town, as far as I can deduce, and in my own personal experience. It's always: Get your A team on the job, schedule it for 8:00 a.m. tomorrow morning, and then we will do it.

Q. All right. And was that the case in 2003, as far as you know?

A. The problem in 2003 again is that there was this -- this time in our medical history when neurosurgeons were not routinely taking call at the hospitals and were not doing aneurysm surgery in this town.

Q. And the neurosurgeons being Dr. Kralick, Dr. Godersky, and Dr. Cohen?

A. Correct. But even if Dr. Kohler were in town at that time, he didn't have privileges at the other hospitals to perform such surgeries, nor did he have backup to perform them. So effectively no one who had the skill would do those surgeries up here during a period of time which may have encompassed the time when Mr. Allen had his problem.

Q. Right. And you -- you're not comfortable rendering an opinion about whether or not it would

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be more desirable for a patient with a ruptured aneurysm to have care down in Harborview versus up here?

A. I can tell you that I know of many patients who have very good outcomes for aneurysm surgery done in Anchorage, Alaska.

MS. McCREADY: Okay. I don't have anything else. Thank you.

MR. GUARINO: Nothing else.

MS. McCREADY: Only because I'm so tired.

THE VIDEOGRAPHER: The deposition is concluded. We are off record at 5:36 p.m.

(Proceedings concluded at 5:36 P.M.)

(Signature reserved.)